CLARK
Institute for Aesthetics

Patient Health History

Name: _____ Date of Birth: ___/___/____

Reason for visit today: _____

Number of children: _____ Ages of children: _____

Any adverse reaction to anesthesia? _____

Currently taking steroids, or within the past year? _____

List Medications, Supplements or None:	Dose:	How Often Taken:

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List Allergies (Drug, Tape, Food) or None:	Reaction:

List Surgeries (including cosmetic):	Date:

Have you been exposed to, or have any infectious disease? _____

Have you had any significant weight change in the past year? _____

Have any major changes occurred in your family in the past year (death, divorce, illness, etc.)?

If so, please explain. _____

Have you received psychological counseling in the past 5 years? _____

Please indicate usage and frequency of the following:

Alcohol ___ (x per week) Tobacco ___ (x per day) Vaping ___ (x per day) Marijuana ___ (x per day)

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Have you ever had any of the following conditions? Please indicate with a check mark.

___ None	___ Blood Clots	___High Blood Pressure	___Heart Disease/ Stroke
___Pacemaker	___Heart Attack	___Irregular Heart Beat	___Heart Murmur/Mitral Valve Prolapse
___Asthma	___Lung Disease	___Shortness of Breath	___Chronic Cough
___Seizures	___Migraines	___Nerve Damage	___Loss of Consciousness
___Hernia	___Acid Reflux	___Stomach Ulcer	___Cancer
___Diabetes	___Thyroid Disease	___Liver Problems	___Kidney Problems
___Cold Sores	___Seasonal Allergies	___Trauma to Nose	___Difficulty Breathing Through Nose
___Dry Eyes	___Blurred Vision	___Cornea Problems	___Wear Contact Lenses
___Chronic Pain	___Depression/Anxiety	___Drug/Alcohol Abuse	___Psychiatric Condition

Please list any conditions you have had not listed above: _____

_____

Most recent mammogram date and results: _____

Family History of:

___Bleeding disorder, Who? _____

___Diabetes, Who? _____

___Stroke, Who? _____

___Anesthesia reaction, Who? _____

___Heart Disease, Who? _____

___Cancer, What type and who?_____

Today's Date: ___/___/___ Patient's signature: _____

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